

Vulnerable Children Project
Benue State, Nigeria

Author: Rose Khasiala Amolo, MPH

Contributing Authors: Chinweoke Onumonu
Uju Edebeatu
Jamoke Onazi

June 2003

The ENABLE Project



The subprojects described in this report were supported by the Nigeria Mission of the United States Agency for International Development (USAID) and by the Office of Population and Reproductive Health, Bureau for Global Health, USAID under Cooperative Agreement No. HRN-A-00-98-00009-00. This document does not necessarily reflect the views or policies of the USAID or the Centre for Development and Population Activities (CEDPA).

Table of Contents

Acronyms	4
Executive Summary	5
1. Introduction	8
2. Background	10
3. Vulnerable Children Project Intervention	11
3.1 Community Entry	11
3.2 Choice of Partners	12
3.3 Baseline	14
3.4 Selection of Orphans	15
3.5 Program Design	16
3.6 Project Implementation	17
4. The Impact of the VCP Project on the Community	20
5. Programming Issues and Challenges	25
6. Lessons Learned	28
7. Next Steps	29
8. Conclusions	31
References	33

Acronyms

ARH	Adolescent Reproductive Health
CBO	Community-Based Organization
CEDPA	Centre for Development and Population Activities
CSO	Civil Society Organization
CWO	Catholic Women Organization
ENABLE	Enabling Change for Women's Reproductive Health
FBO	Faith-Based Organization
IGA	Income-Generating Activities
LGA	Local Government Area
NGO	Non-Governmental Organization
Opiatoha	Opiatoha Kanyi Idoma Multi-Purpose Women's Cooperative Society
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PIC	Project Implementation Committee
PLA	Participatory Learning and Action
PLWHA	People Living with HIV/AIDS
USAID	United States Agency for International Development
VCP	Vulnerable Children Project

Executive Summary

At the request of United States Agency for International Development (USAID)/Nigeria, the Centre for Development and Population Activities (CEDPA) developed the Vulnerable Children Project (VCP) as a response to the growing problem of children affected by HIV/AIDS. The project began in October 1999 and is currently operational in two out of the 20 Local Government Areas (LGA) in Benue State—Otukpo and Okpokwu. The VCP project is a multi-pronged program that targets orphans and vulnerable children (OVC), families (caregivers), local institutions, and state-level structures. The goal of the project is to improve the quality of life for children aged 0-15 years through: 1) The provision of opportunities for orphans, including direct assistance in health and education on an emergency basis; 2) Identification and strengthening of existing community support structures for OVC and people living with HIV/AIDS; 3) Promotion of positive attitudes, belief, and practices surrounding OVC and people living with HIV/AIDS; and 4) developing the capacity of communities to advocate for policy and social change.

Benue State is located in the North Central zone of Nigeria and was selected as an intervention site due to the comparatively high prevalence of HIV/AIDS and the large numbers of households caring for children orphaned or otherwise made vulnerable by HIV/AIDS. Otukpo and Okpokwu LGAs have some of the highest recorded HIV prevalence rates in Nigeria, exceeding 20 percent in these rural communities. The average infection rate for Benue State is 13.5 percent, compared with the national average of 5.8 percent. The 1999 sentinel survey estimated the number of orphans in Benue at 139,650 in 2000 and projected 401,553 orphans by the year 2005.

At the inception of the project, proper community entry protocol had to be followed. A fact-finding team from CEDPA/Washington, CEDPA/Nigeria, Africare, USAID/Abidjan and Pathfinder International visited the community and interacted with people living with HIV/AIDS, orphans and their caregivers, special orphanages, traditional leaders, local government representatives, and local faith-based and community-based groups, including Daughters of Charity, Ohenyeta Care Group, and Opiatoha Kanyi Idoma Multipurpose Women's Cooperative Society. The team held a series of meetings in which they listened as local people enumerated their problems; they also discussed possibilities of suitable interventions. Income-generating activities (IGA) emerged as a priority and a means of strengthening the economic capacity of the community. Finally, an advocacy visit was made to the chief in order to brief him on the findings, garner support, and solicit his approval for the project.

The process of choosing implementing partners proved to be a challenge for CEDPA due to a prior incident highlighting the HIV situation in Ogobia LGA. The Daughters of Charity, an agency that had been providing care and support for people living with HIV/AIDS, had been ostracized from the community because of its involvement in the production of a documentary on HIV/AIDS that led to a community backlash. CEDPA was not welcome in this community and had to change its plans of implementing the project in Ogobia. With the help of the Catholic Diocese Bishop, CEDPA chose the Catholic Women Organization (CWO) as an implementing partner, directing the education and medical

assistance program for the orphans and community mobilization and advocacy. The Opiatoha Kanyi Idoma Multipurpose Women's Cooperative, an umbrella organization that unites all Idoma women's associations, was selected to coordinate the capacity building activities and to manage the income-generating components of the projects.

A baseline study was conducted in July 2000 using a participatory approach with both qualitative and quantitative methods, including: household surveys, focus group discussions with community members and 12-18-year old children, and in-depth interviews with key informants. A total of 600 community members responded to the survey. The survey revealed that: 1) taking care of orphans was a family obligation, suggesting strong extended family bonding and societal cohesion; 2) most of the children were related to the caregiver; 3) caring for an orphan is very common, with an average of 3.6 additional children per household (average number of biological children is 4.5); and 4) families were overextended because of the increased burden evident by the high numbers of children who had dropped out of school, crowded households, and lack of money for food and medical care. There were 3,033 orphans identified and enumerated by the baseline.

The process of selecting participants was also participatory. Community members decided on the following criteria to select orphans who would participate and benefit from this specific project:

- Any child who had lost both parents
- Any child who had lost one parent while the other was sick
- Any child living with a caregiver without a reasonable source of income
- A child who had dropped out of school

Given the limited funds at the start of the project, the community went a step further and decided that the most indigent of those enumerated would benefit from the program. Of the 3,033 vulnerable children identified, 350 children and 227 caregivers benefited during the initial phase of the project; 350 were added in September 2001; and another 300 children in September 2002.

The activities implemented by the CWO and Opiatoha included:

1. Disbursement of school fees and other levies, provision of books, sandals, and uniforms for orphans;
2. Provision of free medical care through selected health institutions in the community;
3. Provision of vocational training for older orphans and caregivers;
4. Capacity building for caregivers in various areas including social mobilization, IGA /micro-credit management training, home-based care training, and basic HIV/AIDS prevention and transmission training;
5. Provision of training in management and implementation of programs including: financial management, supervision, monitoring and evaluation, social mobilization and advocacy training by CEDPA;
6. Establishment and management of the IGA and micro-credit activities;

7. Sensitization rallies and advocacy visits to both state and local government officials to create awareness and advocate for policies favorable to OVC and people living with HIV/AIDS; and
8. HIV/AIDS awareness activities.

The project is a “work in progress” and continues to undergo changes as community and implementing partners learn from experiences. One thousand vulnerable children are now receiving school fees and free medical care. The community has been very responsive by donating land, animal feed, seedlings, and buildings for IGA activities. The local government has provided six field social workers, buildings to house the processing mills for IGA activities, and the project office at Otukpo. Silence on the issue of HIV is slowly unraveling, allowing for sensitization activities such as World AIDS Day, now held every year on December 1st, and community HIV/AIDS awareness activities. The impact the project has had on the community in the first 36 months includes: 1) increased enrollment and lower school dropout rates for the orphans involved in the project; 2) reduction in the level of stigmatization of orphans and their families; 3) enhancement of the self-esteem of the orphans; 4) enhanced capacity of caregivers and implementing partners; and 5) improved access to medical care for the very poor.

Despite the successes mentioned above, the project has experienced various challenges, mainly centered on issues of sustainability, community ownership, stigma, and income generation activities. The “relief” nature of the project has created a lot of dependency, with the project being seen as a CEDPA project rather than a community-owned project. The orphans benefiting from the project are faced with increased jealousy and resentment from the community and family members who are just as impoverished but are not eligible for the free education and medical care. Some of the IGAs have run into problems and been discontinued (pig farm and micro-credit loan schemes), and others are still struggling to take off. Project coverage has been scanty because of limited trained staff and funds. HIV/AIDS prevention activities were not implemented at all in the beginning and on a much smaller scale later because of the silence on the issue of HIV/AIDS, making the project very one-sided. Two of the vulnerable children became pregnant and were expelled from the program by the community stakeholders. Issues and/or problems such as this were not discussed at the inception of the program; without guidelines, they were difficult to deal with.

Next steps focus on modifying the project, by refining its objectives to ensure longer-term sustainability and through strengthening existing community and government structures to provide for OVC and families affected by HIV/AIDS. A multisectoral approach, with emphasis on capacity building of communities and families, community mobilization, economic strengthening, life skills training and involvement of children, are priorities of the next phase of implementation.

Vulnerable Children Project



1. Introduction

In Nigeria, as in many other African countries affected by HIV/AIDS, responses to orphans and vulnerable children (OVC) have relied upon the extended family networks. Now, with increasing numbers of orphans, the traditional social safety net is now unraveling, and the capacity and resources of family members – many of whom are already impoverished themselves, have been over-extended. Very few social support systems outside the family exist in sub-Saharan Africa. Even where basic social services are provided, they tend to be largely inadequate. Those children who slip through the traditional safety net often end up in the cities as street children, working children, or living in child-headed households (Subarao and Coury, 2003).

Most interventions in support of OVC in sub-Saharan Africa are relatively new, with very limited documentation of best practices or insights into OVC programs' cost effectiveness and sustainability. With new attention being paid to the problems of OVC, spontaneous responses have rapidly burgeoned, with interventions being sporadic, piecemeal, and poorly planned.

Because the most visible effects on a family supporting OVC and people living with HIV/AIDS are economic, the majority of interventions focus on distribution of school and

health subsidies and food, as well as income generation. A review of existing programs in sub-Saharan Africa reveals five main models that serve to meet the needs of OVC:

- (1) Family responses, through fostering children by the extended family or fostering with subsidies to families supporting orphans.
- (2) Direct service delivery, in which schools and/or health vouchers/subsidies are distributed to improve the general welfare of children and ensure continuation of their education. Most of these are donor funded.
- (3) Community-based responses, which include activities to advocate and mobilize resources within the community, the private and public sectors and external donors to support the families and OVC. They include local grassroots and non-governmental organizations (NGOs), civil society organizations (CSOs), women's groups, and faith-based organizations (FBOs). Several of these organizations benefit from donor-funded capacity building and training in the areas of care, including nutrition and psychological support, education, and income-generating activities. Many engage in community fundraising activities, donations of land and material resources, and volunteering time on community-operated projects.
- (4) Government responses. Because of the generally weak African economies, which are beset by constant market failure, debt, corruption, and most importantly, overwhelming poverty, most public-sector responses have been minimal. A few countries such as Uganda and Kenya have implemented a broader policy on education (Universal Primary Education), which has clearly assisted the OVC. In Botswana, the government has established a National AIDS Orphans Programme (NAOP) in partnership with NGOs, community-based organizations (CBOs), and the private sector. The NAOP coordinates capacity building activities, welfare of orphans, identification and registration of orphan data, and identification of needs of fostered orphans and their parents. Other countries are aggressively seeking funds from both bilateral and multilateral donors.
- (5) Institutionalization through orphanages is often the last resort, especially for displaced or abandoned children, children in child-headed families, and street children. Orphanages run by religious groups often attract huge donor and charitable funds.

So far, community-based models that support foster families, within or outside the extended families, seem to be the most promising. The involvement of the community in raising funds, care, and support has the potential to improve the welfare of orphaned children, thereby reducing the burden placed on individual families. However, community-based models should also seek to limit the potential for abuse by relatives, such as withholding of food, education, and health care within foster families (Deininger, et al. 2001).

In response to the growing numbers of children orphaned and affected by AIDS in Benue State, USAID/Nigeria requested that CEDPA develop the Vulnerable Children Project (VCP) in October 1999. The urgency of their request resulted in a program that was relief-oriented, focusing on direct assistance to the orphans, caregivers, and their families.

Over time, the VCP expanded its response to improve the quality of life of the OVC, extending beyond direct service delivery and assistance. Strategies have included capacity building of caregivers and family members, social mobilization of the community to respond to children's needs, stigma reduction, and income-generation. The project utilizes a community-based model to support extremely indigent orphans and their caregivers and was implemented in collaboration with two local NGOs, Catholic Women Organization (CWO) and Opiatoha Kanyi Idoma Women's Cooperative Society (Opiatoha). A similar USAID/Nigeria-funded project, administered by CEDPA and implemented by Africare, is currently in operation in Rivers State.

This report summarizes the program design, implementation, accomplishments and challenges, lessons learned, and future directions for the Vulnerable Children Project in Benue State, Nigeria. The information is drawn from a number of documents, including narratives, baseline participatory assessments (survey, focus group discussions, and key informant interviews), monitoring data (service records) and several recent midline assessment reports. The report's purpose is to help refine scaling up the VCP, as well as to inform others who wish to implement similar programs.

2. Background

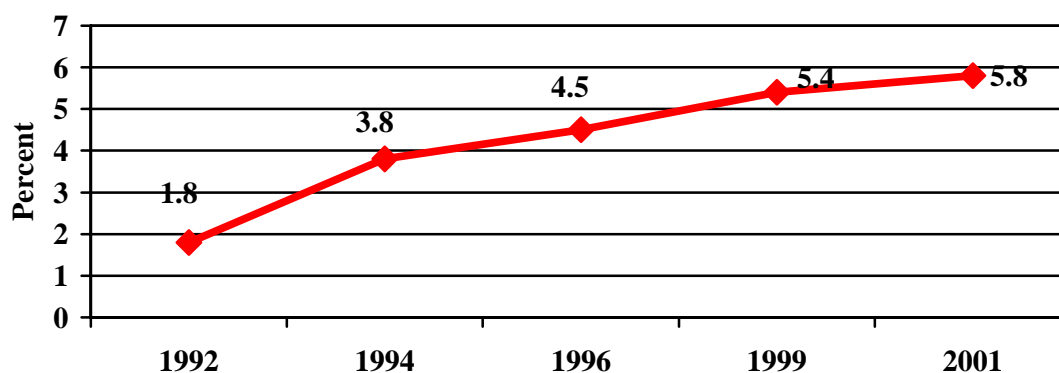
Today more than 13 million children currently under the age of 15 have lost one or both parents to AIDS, most of them in sub-Saharan Africa.¹ This number is expected to increase to more than 25 million by 2010. In addition to increasing the number of orphans², the AIDS crisis has changed the nature of risks faced by households and communities, expanded the human development agenda of many African countries, and threatened the caregiving capacity of communities (Deinger, et al. 2001). In 2001, 12 countries in sub-Saharan Africa accounted for 70 percent of the orphans, with Nigeria, Ethiopia, and Democratic Republic of the Congo accounting for the greatest number of orphans (UNICEF, et al. 2002).

Nigeria has experienced a 300 percent increase in HIV sero-prevalence over the last 12 years, making it the country with the highest number of HIV-infected people in West Africa, with 10 percent of all the HIV infections worldwide. The current national prevalence is 5.8 percent. The Government of Nigeria reports that 3.5 million Nigerians are living with HIV/AIDS and that 900,000 children have been orphaned by AIDS (USAID/Nigeria 2001, UNAIDS 2002). With the current trend, it is estimated that the percentage of orphans due to AIDS will continue to rise, increasing to 2.6 million in the year 2010³ (UNICEF, et al. 2002).

¹ Sub-Saharan Africa bears by far the greatest burden: 12% of all children in this region are orphans, compared with 6.5% in Asia and 5% in Latin America (UNICEF, et al. 2002).

² Of the more than 34 million orphans in sub-Saharan Africa, about 11 million are due to AIDS; by 2010 5.8% of all the children in the region will be orphaned by AIDS.

³ The estimated total number of orphans due to all causes in 2010 in Nigeria is 6.7 million (UNICEF, et al. 2002).

Figure 1. Median National HIV Prevalence Increase, 1992 – 2001

Source: POLICY Project, The Futures Group. *HIV/AIDS in Nigeria: Overview of the Epidemic*. (Washington, DC: The Futures Group, 2002).

Benue State, one of the hardest hit areas of Nigeria, has an HIV sero-prevalence rate of 13.5 %. This rate, even though down from the 2000 high of 16.8%, remains the highest in Nigeria (Ministry of Health, 2001). According to the 1999 national sentinel survey, the estimated number of orphans in Benue in 2000 was 139,650 and was projected to be 401,553 by the year 2005 (Policy Project, 2002). The socio-economic impacts of HIV/AIDS in Benue State, as in the rest of Nigeria, include reduced life expectancy, increased burden of medical care, increased number of OVC, and a decline in economic growth.

A baseline study conducted in 2000 found that caregivers and their families experience various financial, medical, nutritional, and emotional difficulties that lead to the following areas of need: health care, education, lack of adequate nutrition, economic strengthening including income generation, vocational training, emotional and spiritual support.

The **goal** of the Vulnerable Children Project currently being implemented in two Local Government Areas (LGAs)—Otukpo and Okpoku—is to improve the quality of life of vulnerable children. The **objectives** are as follows:

- Provide opportunities for orphans including direct assistance for health and education on an emergency basis;
- Identify and strengthen existing community support structures for OVC and people living with HIV/AIDS;
- Promote positive attitudes, belief, and practices surrounding OVC and people living with HIV/AIDS; and
- Develop the capacity of communities to advocate for policy and social change.

3. Vulnerable Children Project Intervention

At the request of USAID/Nigeria, CEDPA developed the Vulnerable Children Project (VCP) in October 1999 to provide relief to families who were taking on the added responsibility of caring for one or more of children affected by HIV/AIDS. The original plan was provision of school and health vouchers for the children, but to provide more comprehensive assistance, CEDPA used a participatory approach to include the community members in the planning and to solicit ideas on the kind of interventions that would be suitable for them. The project was originally implemented in three communities— Akpa, Asa/Babylon, and Ojapo located in the Otukpo and Okpokwu LGAs. The project has now expanded to include four additional communities— Ogwonuigbahapa, Idobe, Upu/Otukpo-Icho and Obaganya.

3.1 Community Entry

Project activities began in October 1999 with a fact-finding team from CEDPA/Nigeria, CEDPA/Washington, Africare, USAID/Abidjan, and Pathfinder International visiting the community to establish a relationship and gain knowledge about the realities on the ground. There they interacted with people living with HIV/AIDS, the Daughters of Charity⁴, a special orphanage, traditional leaders, local government representatives, orphans and caregivers from St. Mary's Hall—Otukpo and local groups, including the Ohenyeta Care Group (OCAG), Opiatoha Kanyi Idoma Multipurpose Women's Cooperative (Opiatoha). The goal of the visit was to meet with the involved stakeholders, listen to and enumerate their problems, and to come up with interventions acceptable to the communities. These discussions led to the decision that the intervention should cover four groups, namely, the OVC, the caregivers, local community organizations, and the state government. A series of stakeholder meetings were held to identify the best possible interventions at the community level, based on the realities of the community. Income-generating activities (IGAs) emerged as a priority for economic strengthening and as a means of raising the general well-being of the people in the area. In this farming community, dubbed "the bread basket of the nation," agricultural-based IGAs were most appealing; the skills existed in the community and some of the produce would go towards the nutritional needs of the vulnerable children and their families. Suggestions for various IGA ventures included a rice mill for the Otukpo community, a palm oil processing plant for Akpa, and a gari processing plant for Okpokwu. Finally, the team made an advocacy visit to the traditional leader of the Idoma tribe, O'Chi'Idoma, to brief him on the findings, to solicit his approval, and to garner his support.

3.2 Choice of Partners

Initially, the Daughters of Charity were chosen to take care of the health and education components of the project. These nuns had been providing care and support for people

⁴ A group of Catholic nuns who work with and care for people living with HIV/AIDS and orphans.

living with HIV/AIDS in the area for several years. However, a documentary about the local HIV/AIDS situation aired on national television disturbed the audience and led to a distancing from the people of Ogobia. The nuns were involved in the arrangements of making of the documentary for what they deemed as good reasons—awareness creation to attract donor help. They did not anticipate the negative reaction from the community. This led to the rejection of the intervention and ostracism of the Daughters of Charity by the community. Given the situation, the Daughters of Charity declined to be involved in the program.

CEDPA/Nigeria staff, including the former Country Director Dr. Enyantu Ifenne, who was a native of the area, tried to broker peace. Key gatekeepers were identified, including a youth representative, and a meeting was convened. The meeting was not fruitful. The community openly told CEDPA that they did not need HIV/AIDS campaigns and that CEDPA should find an alternative community in which to work.

After CEDPA's initial effort to win back community acceptance failed, the team approached the Catholic Bishop of Otukpo, who advised them to work with the Catholic Women Organization (CWO), as he had faith in the women's commitment and the support they would provide for the program. Though inexperienced in implementing HIV/AIDS community programs, their membership consists of professional nurses and teachers, whose skills and experience could be tapped for the project. CWO, therefore, was to implement the health and education portion of the project.

Opiatoha Kanyi Multipurpose Women's Cooperative Society (Opiatoha), an umbrella organization that united all Idoma Women's Associations, was selected by CEDPA on the grounds that 1) it focused on women issues, such as caring for people living with HIV/AIDS and OVC; and 2) it was a credible, *de facto* representative organization. Opiatoha was charged with the responsibility of identifying orphans and building the capacity of caregivers in the area of income generation.

Community Reaction to Media Publicity

Prior to the start of the VCP project, a documentary on HIV/AIDS in Otukpo was aired by the Nigeria Television Authority during the prime time program, *Newsline*. The focus was on Ogobia, one of the communities CEDPA had intended to work with. The program, which intended to create awareness about the grave situation of HIV in the area, instead had a negative impact on the community. The farmers could not sell their produce and the young men who tried to enlist in the police force were rejected. Stigma and discrimination from the surrounding communities intensified and they were often referred to as "the AIDS community." This gave way to silence in the community about HIV/AIDS, and no one dared to talk about it.

The Daughters of Charity, which had collaborated with Pathfinder International and the team that produced the documentary, became the subject of violent threats and anger from the community. The nuns had to abandon their convent and the community service they had been offering to the sick. The nearby St. Joseph's Hospital, which was caring for HIV/AIDS patients, denied the existence of the disease in the community.

Catholic Women Organization

The Catholic Women Organization (CWO) in Otukpo was established in 1950 as a structure within the Roman Catholic Church to promote the rights and welfare of women in the parishes. Currently the diocese has five deaneries and 30 parishes. CWO is run by a ten-woman Executive Council (seven elected and three *ex officio* members) and headed by a president. Members of the organization meet monthly at the parish and diocesan levels. Membership is drawn from the nine LGAs in Idomaland—Ado, Apa, Agatu, Okpokwu, Oju, Ogbadibo, Ohimini, Obi and Otukpo—and attracts a wide range of Catholic members, including professionals, academicians, civil servants, self-employed women, and farmers. Funds for the organization's activities are raised through annual membership fees and levies.

CWO had earlier established a relationship with CEDPA when it received funds to implement a democracy and governance project, which aimed at empowering women through grassroots mobilization (Olajumoke, 2002).

Opiatoha Kanyi Idoma Multipurpose Women's Cooperative Society (Opiatoha)

Established in 1993, Opiatoha is an umbrella organization for all Idoma Women's Associations in Benue State. Like CWO, its membership is spread across nine LGAs in the state, which comprise Idomaland. Presidents and secretaries of more than 100 women's associations belong to Opiatoha. Opiatoha's goal is to reach every woman and help alleviate problems affecting them, including HIV/AIDS. Association meetings are held fortnightly to discuss the general well-being of women and children. They also discuss how to meet the basic psychological and economic needs of those infected and affected by AIDS.

3.3 Baseline

Using Participatory Learning and Action (PLA), a study was conducted in June 2000 to gain the information necessary for program implementation and to establish the baseline for monitoring and evaluation of program activities. Both qualitative and quantitative methods were used, including a household survey of caregivers, focus group discussions with community members and children 12-18 years old, and in-depth interviews with key informants. The study involved the community in characterizing the issues and was the first step in mobilizing the community members to address the serious needs of vulnerable children. A total of 600 community members responded to the survey.

The baseline found that the VCP project community areas of Benue State were predominantly inhabited by the Idoma people, who engaged in poor subsistence farming and petty trading (65% and 22% respectively), earning a mean average of N 1,165 (US \$7.95) a month, or N 13,872 (US \$94.70) annually. The mean number of biological children under 16 years was 4.5 per family. The mean number of additional vulnerable children was 3.6 per household. These data indicate a high level of fostering and exchanging children among extended family members at baseline. Qualitative research confirmed that fostering was culturally acceptable.

Table 1: Distribution of the Relationship of Caregiver to Orphans

Relationship of Caregiver	Number of Orphans		
	Males	Females	Total
Mother	3	6	9
Grandmother	4	3	7
Aunt	2	3	5
Uncle	1	2	3
Elder brother	2	1	3
Father	2	-	2
Elder Sister	1	1	2
Cousin	-	1	1
Stepmother	-	1	1
Total	15	18	33

Table 2: Distribution of Orphans by Duration of Stay with Caregiver

Duration	Number of Orphans*		
	Males	Females	Total
Up to 1 year	2	2	4
2 years	1	2	3
3 years	2	4	6
4 years	1	-	1
5 years and above	4	1	5
Total	10	9	19

* The 11 children staying with their parents are not included.

Taking care of orphans appeared to be a family obligation, suggesting strong extended family bonding and societal cohesion, which unfortunately did not always translate into strong commitment by the community for the care of orphans. Only about 13 percent of the orphans had received food items, and 8 percent had received gifts including cash from family members, neighbors, church, politicians, and other sources. Community support for orphans was negligible. The survey found that only 7 percent had received help from the church, and another 7 percent from neighbors. Two-thirds (67%) of the respondents reported receiving no help from the community. Money for health/medicine,

education/schooling, and food was identified by the caregivers (42%, 40%, and 15% respectively), as the most pressing special need. Three out of four (74%) of the caregivers felt the need to talk to someone about their situation, demonstrating the high level of emotional and psychological trauma. The increased number of family members because of fostering orphans further burdened the limited housing space (Adekunle and Isiugo-Abanihe, 2002).

The baseline study identified and enumerated 3,033 vulnerable children, listed assets that could be mobilized to alleviate the problems for OVC, and explored the knowledge, attitudes, and practices within the community vis-à-vis orphans, caregivers and people living with HIV/AIDS. It identified several areas of need: health care, education, nutrition, vocational training, income generation, emotional support, and spiritual succor.

3.4 Selection of Orphans to Participate

Given limited funding, CEDPA could only provide for 350 of the 3,033 children enumerated. A process and criteria agreeable to the community had to be established. Therefore, a project governing board and a project implementation committee (PIC) were initiated, comprised of representatives of the partner organizations and other stakeholders. The baseline confirmed that those orphans who had lost both parents or who had one surviving but sick parent were at most risk. The challenge was isolating those orphans who were the most indigent in a community where poverty is rampant and talking about HIV/AIDS was taboo. Using a participatory approach it was decided that the following criteria would be used:

- Any child who had lost both parents;
- Any child who had lost one parent while the other was sick;
- Any child living with a care-giver without a reasonable source of income; and
- A child who had dropped out of school.

PIC members then assisted community members in filling out the necessary forms. Out of the approximately 3,000 forms completed, 350 children under 15 years of age were determined to be most at risk. The children were chosen from the three intervention communities as follows: 143 from Akpa, 125 Asa/Babylon, and 82 from Ojapo. For purposes of transparency and trust building, the community members agreed that the list had to be verified through an open process. Each community arranged for a place and time in which the traditional ruler and members of community met and the names of the orphans selected were read out. Community members were then given the opportunity to publicly accept or reject the choices made. The process was widely accepted and provided for a smooth start of project activities. In addition, 277 caregivers were chosen to benefit from the micro-credit scheme, vocational training, and IGAs.

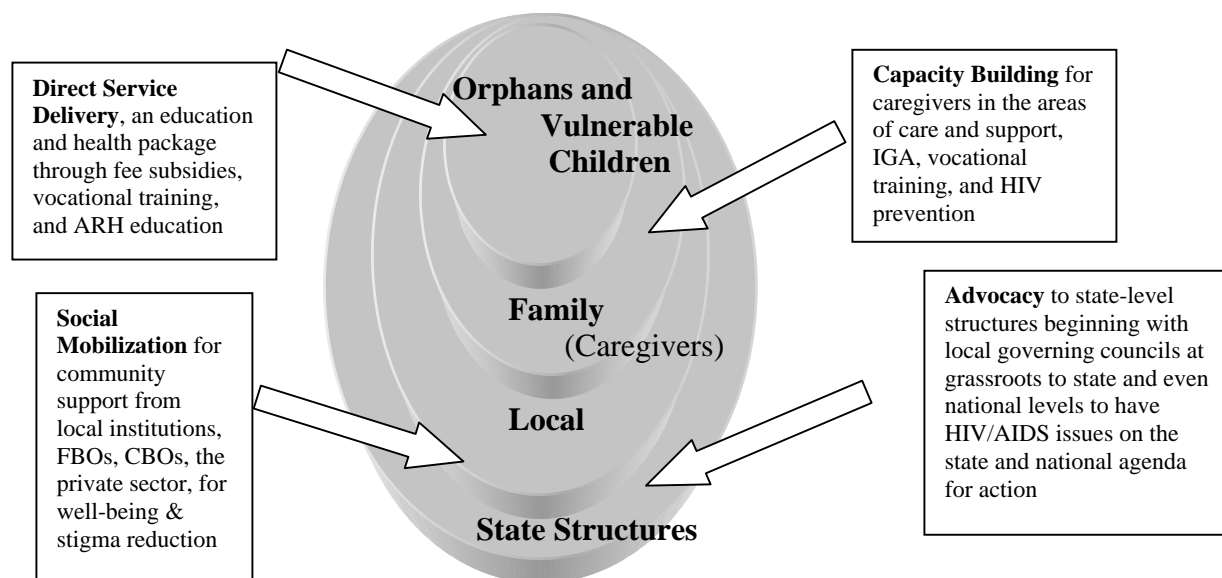


Community meeting to discuss the selection of children to participate in the project.

3.5 Program Design

The VCP is a multi-pronged program that targets OVC, families (caregivers), local institutions, and state-level structures. The relief aspects of the project are focused on the orphans. However, a variety of capacity building, social mobilization, and advocacy activities are directed at the family/caregivers, local institutions (churches, private businesses, CSOs, NGOs, etc.) and state-level structures. These interventions are intended to garner financial and social support at all levels to strengthen community responses and empower families economically, thereby reducing stigma.

The model below demonstrates the various levels of society that the VCP project reaches.



3.6 Project Implementation

Implementation began in early 2000. As mentioned earlier, two local grassroots organizations, Catholic Women Organization (CWO) and Opiatoha Kanyi Multipurpose Cooperative Society (Opiatoha) were chosen to implement the education and health, and capacity building and IGA/micro-credit training respectively. Since these grassroots organizations had limited organizational capacity to successfully implement the project, CEDPA provided the initial training of trainers in social mobilization focusing on HIV/AIDS. Other training workshops included life skills training, income generation and vocational skills training for the caregivers. CEDPA also provided a start-up workshop for the project directors, coordinators, and accounts clerk with the aim of improving administrative and financial management, implementation strategy, and data collection and reporting skills. Below are the detailed project activities implemented in partnership with CWO and Opiatoha.

CWO Activities

1. At the beginning of the project, CWO established two committees:
 - **The Diocesan Level Committee**, made up of members of the Executive Council and others with relevant professional background. This committee lobbies policy makers and advocates within the traditional support system for orphans. Throughout the project, the committee made advocacy visits to policy makers, particularly at the local government and traditional institutions, which

- contributed to the strong support for the project and the amount of resources leveraged from community leaders and government institutions.
- **The Project Implementation Committee (PIC)** consists of community members and opinion leaders who are charged with the day-to-day implementation of the health care, nutrition, basic education, vocational, and spiritual care project activities, as well as increasing awareness of HIV/AIDS within the communities.
2. The disbursement of school fees and levies and provision of free health for the children commenced in 2000.
 - a. The schooling package includes provision of tuition and other school levies, books, uniforms, and vocational training for older orphans.
 - b. The health package provides free medical treatment for the orphans, with immunizations. The PIC identified the health facilities—St. Theresa’s Hospital in Otukpo, a primary healthcare center (PHC) in Otobi, and the Family Support Programme (FSP) clinic in Ojigo, to which all the orphans have access depending on their locality. The arrangement was such that CWO directly paid the costs of health incurred from use by project participants to the health institutions. The health institutions had a list of names of the participating children.
 3. Management of the Piggery. Even though CWO was charged with the education and health component of the project, they undertook the management of the pig farm, at the request of the PIC and community members, who saw it a viable and quick way of generating income. Pork is a delicacy in high demand within the community, therefore good returns were conceivable.

The Asa/Babylon community was the first to set up a pig farm, with the help of their Local Government Chairperson, who donated 14 piglets, paid the rent, and renovated the farm, which had been abandoned by a previous farm owner. Caregivers who were members of Opiatoha received a three-day pig management training in Otukpo, followed by technical assistance from the Department of Agriculture on feeding and health care of the animals. CEDPA provided the initial funds for the feed, while the women were responsible for feeding and general upkeep of the farm. In a few months the number of pigs had risen to 60.

Unfortunately because of disagreements among the caregivers on various issues such as when or at what stage the sale of the animals should occur and the high cost of animal feed for the fast-growing animals, the project ran into problems. To resolve the issue, each caregiver was given a pig to raise individually, thus supporting 18 caregivers. The rest of the pigs were sold in July 2002, and the money was used to provide micro-loans to the caregivers who received the pigs (Sussman, 2002).

4. CWO provided vocational training to caregivers.



Piggery Management Training

Opiatoha Activities

Because of its reach throughout the Idoma society, Opiatoha participated in the initial identification of orphans and screening of the most indigent. Their other activities focused on:

1. **Training** to build the capacity of caregivers to generate income and mobilize for support. Since the communities had been involved in identifying viable income-generating activities, the training was centered on the process of set-up and management of specific activities, such as cassava (garri) processing, pig farming, and rice milling. Opiatoha manages the rice mill and the palm oil processing plant. The trainings offered are as follows:
 - **Vocational training:** 36 older siblings and 44 caregivers were enrolled in vocational training (tailoring, carpentry, soap making, driving, mechanics, hair dressing, and computer skills) at the time of the evaluation.
 - **Social mobilization training:** (1) PIC members received training in social mobilization, advocacy, networking, and gender issues. (2) CEDPA conducted a TOT for social mobilization among participating NGOs and CBOs.
 - **IGA/Micro-credit training:** For caregivers to improve their capacity to carry out micro-credit and business management activities. About 413 women benefited from an exchange program with COWAN, where they visited COWAN projects in Ondo State and observed first hand how they worked.

Thirty CWO participants (27 women and 3 men) were trained in the techniques of successful pig farming.

- **Field testing of the “Home Care for People Living with HIV/AIDS” Manual:** Twenty-five caregivers from Otukpo benefited from a field-testing activity in October 2002, to enhance their skills in nutrition and basic management of ailments of people living with HIV/AIDS and psychosocial and emotional support of OVC.
- **Training workshop:** A start-up workshop was conducted on May 17, 2000 for VCP project implementing staff to improve their management and training skills.

2. Establishment of **income-generating Activities (IGA)** and **micro-credit-schemes**. Upon completion of training, Opiatoha established appropriate IGAs in three communities—Ojapo (cassava), Asa/Babylon (rice), and Akpa (palm oil). The mills are all housed in government-donated buildings, which were renovated through the collective effort of the communities contributing time and labor. This was done between October to December 2001.

- The **Rice Mill** was launched in Asa/Babylon, Otukpo on February 15, 2002. The project hires caregivers and other Opiatoha members to run the mill. For a fee, customers bring their parboiled or raw rice to the mill for processing. However, as of September 2002, the mill had not done well due to the seasonal nature of the crop. The caregivers were waiting for the harvest season. The overhead to run the mill was proving to be high, and suggestions had been made to turn the project into a cooperative. However, the Opiatoha women prefer to run it by themselves and have pledged to raise funds for that purpose.
- **Cassava Plantation and Gari Mill** in Ojapo. Caregivers and other CWO members (35) work the community-donated land and take turns in harvesting, milling, and processing of the garri. Community members are encouraged to bring their cassava for processing (for a small fee). Although cassava is plentiful and the demand for garri is high, the output has been lower than expected because of the location of the mill. It is not located on a major thoroughfare or near major community activities. Improved access to the mill would enhance its earning potential and sustainability.
- **Palm Plantation and Palm Oil Press** in Akpa. Donated seedlings were planted. The Palm Oil Press is not yet in operation.
- **The Piggery** was managed by CWO as mentioned in the previous section, but Opiatoha was responsible for coordination the training activities to build the women’s pig farming skills in conjunction with technical assistance from the Country Women’s Association of Nigeria (COWAN). To increase access of caregivers to credit schemes, CEDPA linked Opiatoha to COWAN, a group headquartered in South West zone of Nigeria. In January 2000, Opiatoha, with assistance from CEDPA/Nigeria, collaborated with COWAN to organize a workshop introducing strategies for augmenting their income. The collaboration with COWAN in micro-credit schemes and IGA activities led to the establishment of a COWAN chapter in Benue State in June 2000. COWAN

expanded its role to include social mobilization, women's rights, and technical mentoring for IGA/micro-credit scheme. During April–June 2001, more than 500 caregivers received seed grants totaling N500,000 (\$5,000) under the “poorest of the poor assistance” scheme. Unfortunately, this operation has since collapsed for the following reasons: 1) the interest rates were too high; and 2) COWAN was unable to monitor the borrowers and thereby recover its loans (Sussman 2002, Isiugo-Abanihe 2002).

3. **HIV/AIDS awareness activities.** CEDPA conducted social mobilization training for Opiatoha members that stimulated their efforts in mobilizing community members, church groups and other stakeholders around the silence of the issue of HIV/AIDS in their community, which had prevented any efforts to conduct prevention activities. Opiatoha collaborated with Ohonyeta Care Group (OCAG) to present a one-day workshop on “The Role of the Church in HIV/AIDS Control.” The aim of the workshop was to involve religious organizations and clergy in the fight against the spread of HIV/AIDS. Sixty Christian and Muslim religious leaders attended. During World AIDS Day events Opiatoha participated in the distribution of HIV prevention materials.



4. The Impact of the VCP Project on the Community

The VCP project is a work in progress; it continues to undergo changes as the community and implementing partners have experiences that were not anticipated at the initial planning of the project. The impact stated below is based on the first three years of the intervention, October 1999 - November 2002. An evaluation done in December 2000 by U.

C Isiugo-Abanihe singled out the disbursement of tuition fees and other school-related expenses, and to a certain extent medical vouchers, as the most valued component of the project by both the OVC and caregivers.

1. Increased school enrollment and lower dropout rates.

CEDPA's Quarterly Service Statistics Report (QSSR) at the end of 2002 reported that about one-third of orphans identified at the baseline were enrolled in school. The evaluation done at the end of the project shows that orphans enrolled in the project were attending school on a regular basis and there were no incidences of expulsion due to non-payment of school fees, lack of uniforms and books. The focus group discussions revealed that prior to the subsidy, the 83% who had reported being registered in school at the time of the baseline were actually not physically attending class because of expulsion for fees and other levies. All of the 17% who had reported not being in school were now enrolled in the program and attending school. Thus the education package is acclaimed by the community to be the most important aspect of the project. With a grant from CEDPA, CWO initially supported 350 orphans from the Otukpo and Okpokwu LGAs, providing them with school fees, textbooks, uniforms, sandals (for all grade levels), health care, and vocational training (for older OVC). Given the large numbers of orphans in the area, CWO received additional funds and increased the number of orphans receiving the education grant to 700 and expanding their reach to two more sites, Obaganya and Upu, in September 2002. An additional 300 children were added to the program towards the end of 2002, bringing the total number to 1,000 and expansion to seven communities. About 58% of them are currently in primary school, 35% in secondary school, and 6% in vocational training (tailoring, carpentry, soap making, driving, mechanics, hair dressing, and computer skills). The remaining 2% are either under five or have relocated (Isiugo-Abanihe 2002).

An assessment of the academic performance of the OVC in the project, conducted by field supervisors, shows that approximately 1 in 10 students are performing excellently, 63% are rated as good, and 20% satisfactory or average; only 6% were rated as performing poorly or below average. A focus group discussion with the principals and 34 OVC in the project confirmed that they were generally doing well in their studies, exhibiting industry and high levels of motivation. This is another important educational benefit applauded by the community.

2. Reduction in the level of stigmatization.

At the onset of the project, any mention of HIV/AIDS was taboo, stigma was high, and it was impossible to conduct any prevention activities. Project staff talked of orphans and implemented an OVC project without any mention of HIV/ AIDS, and no prevention activities were tied to the project at first. The participatory approach of including traditional and political leaders, stakeholders, religious leaders and groups, and community members, coupled with training in basic HIV/AIDS transmission and prevention facts and social mobilization, have really helped in creating awareness. Silence on the issue of HIV/AIDS is loosening, contributing somewhat to the reduced level of stigmatization and acceptance of families affected by HIV/AIDS and orphans in school. The community now allows big events such as World AIDS Day where IEC materials are passed out, networks

of people living with HIV/AIDS have formed and are operating freely, and more and more community members are participating in care and support activities.

Another aspect of the program that has helped the orphans to be accepted is the privileges that the orphans enrolled in the program currently enjoy. They are no longer seen as dirty and sick, they have clean uniforms and school supplies, and then are going to school with minimum disruptions. The following quotations from the focus group discussions describe some of the children's feelings about attitudes towards them:

- *“They now look at us as responsible children; as if we have parents again.”*
- *“We are happy when they talk good of you now. Not like before when they call us names and associate us with one evil or another.”*
- *“They treat us well now, because we are not like we were at first. There has been a change in our lives and they know it. They treat us as those who have parents.”*
- *“There is no discrimination now. The fact that I am now in school has removed all bad feelings. The attitude of the people has changed toward orphans.”*

3. Enhanced self-esteem among OVC.

Participation of the OVC in the school program and vocational training is the single most important factor in raising their self-esteem. The OVC feel with education they can look forward to an optimistic future. They feel equal to other children in the community, and also feel more respected and accepted by their community, reducing the sense of hopelessness that they experienced after the death of their parents.

The informal pep talks by the field supervisors and members of the Catholic Women Organization have been key to encouraging the children to think positively and reinforcing the need to stay focused in order to succeed, as well as helping them deal with their daily emotional and developmental problems.

4. Greater capacity of caregivers and community organizations.

CEDPA engaged in various training activities—the project start-up workshop (finance management, monitoring and evaluation, project implementation and supervision, development of work plans), social mobilization, vocational training, home-based care training, basic HIV/AIDS transmission and prevention education, and income-generating/micro-credit training that enabled the community groups to mobilize for support and advocate for OVC and families affected by HIV/AIDS. Their activities reduced the level of stigma and enhanced the skills of caregivers and older orphans to enable them to participate in income-generating activities or paid employment.

The implementing partners and the community leaders now confidently use their social mobilization skills to mobilize for resources and bring the community together, create

awareness about HIV/AIDS transmission and prevention, and involve the church and other community groups in HIV/AIDS prevention, care and support activities.

HIV/AIDS awareness campaigns conducted in collaboration with other community groups have contributed to the almost universal knowledge of HIV/AIDS and are contributing greatly to the loosening up of the community and readiness to discuss HIV/AIDS in their community. Some of the activities are as follows:

- World AIDS Day events (December 1st of every year since 2001) have been conducted annually in project areas. PIC members who were trained in HIV/AIDS transmission and prevention play a crucial role in setting up and conducting these events. Activities during these campaigns include rallies/floats, street drama songs, dances, talks on HIV/AIDS, distribution of IEC materials and advocacy visits by PIC members to opinion leaders, policy makers, religious leaders, and school authorities. The events have been very successful in that more people are approaching PIC members to clarify misconceptions and improve their understanding of HIV/AIDS; they have expressed interest in building networks with other local NGOs for wider reach of such activities.
- The workshop mentioned earlier, ‘The Role of the Church in HIV/AIDS Control,’ was a first step in sensitizing local clergy to the issues related to HIV/AIDS. Sixty Christian and Muslim religious leaders attended.

Community mobilization activities and participation of informed leaders have resulted in various community and government-level contributions, which include:

- 1) The state government donated buildings that house the IGA.
- 2) The Akpa community donated farmland for the palm plantation.
- 3) 3,000 palm seedlings were provided by Otukpo LGA to meet the long-term need of the oil palm mill.
- 4) Okpokwu LGA provided a piece of farmland and a tractor, as well as help in cultivating and planting improved cassava stems in Ojapo.
- 5) Benue State Ministry of Agriculture provided four hectares of land at Ojapo, four bags of maize seeds, 15 litres of herbicides, 26 bags of fertilizer and a tractor.
- 6) The Ojapo community provided direct labor in land—clearing for cassava.
- 7) Salaries for five field social workers paid by LGA Ministry of Health.
- 8) The Otukpo LGA chairman donated three bags of rice and maize each, and seven blankets to project orphans.

Involvement of the traditional leaders in the planning and training activities from the inception of the project has helped in mobilizing community support. The traditional chiefs were actively involved in leveraging resources and made considerable efforts to sensitize the community, stakeholders and state and local governments to the needs of children, families and caregivers.

Social mobilization has also created awareness among the stakeholders of community problems, especially HIV/AIDS and has encouraged community participation in finding solutions.

The vocational training offered to both caregivers and older orphans who had dropped out of school is regarded as an asset to most of the participants. Even though the promise of giving sewing machines to the caregivers who took the tailoring course did not materialize, they still feel they can be employed and hope to start their business in the future.

Caregivers were also given a general training in small business management and micro-credit schemes. Most of the income-generating activities are agricultural-based and at the initial stages. Therefore they have not yielded much in monetary terms, but the caregivers are hopeful about the yield during the harvest season.

5. Improved access to medical care for orphans.

Only one in four (182 out of 654) enrolled children utilized the free medical services provided under this project. Nevertheless, those who received treatment are the most indigent, and many children's lives were saved from life-threatening conditions such as typhoid fever, pneumonia, gastro-enteritis, measles, chicken pox and appendicitis. Uche Isiugo-Abanihe's evaluation of the health records show that 93% of the 182 children used St. Theresa's hospital in Otukpo Urban, 3% Otobi clinic, and 4% the Family Support Program clinic at Ojigo. The two communities of Asa/Babylon, and Ogwonuighapa, with close proximity to the health institution (St. Theresa's Hospital), had the highest numbers of OVC attaining health services. Table 3 shows the number of OVC by community, use of the project health institutions.

Table 3: Number of OVC by Community and Medical Treatment

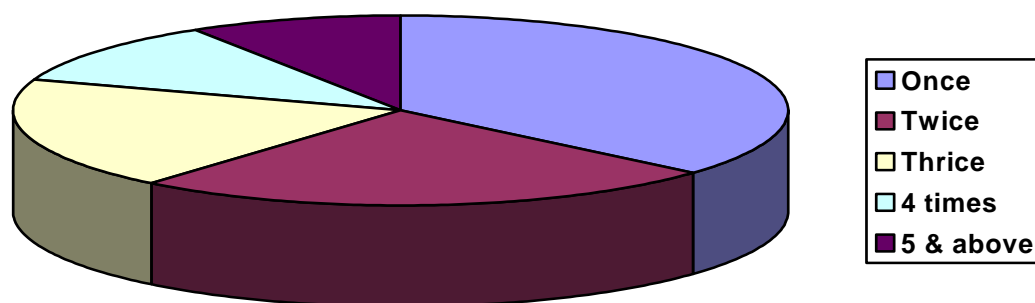
Community	Number of OVC	Number Treated at Project Health Institutions (%)
Ogwonuighahapa	247	98 (40)
Asa/Babylon	118	50 (42)
Idobe	89	21 (24)
Ojapo	72	7 (10)
Otobi/Akpa	128	6 (5)
Total	654	182 (28)

*Source: Isiugo-Abanihe, 2002

Of the 182 OVC being treated, 27 percent and 53 percent came from Asa/Babylon and Ogwonuighapa. Orphans from remote areas were less likely to be treated at St. Theresa's Hospital. Only 21 orphans from Idobe and none from Ojapo and Otobi were seen at St. Theresa's Hospital. OVC from these communities were served by other primary health

clinics, which generally have low patronage because of the limited services available. Focus group discussions revealed that the cost of transportation to project hospitals or Primary Health Care (PHC) centers is a major deterrent for OVC seeking medical attention. Many caregivers prefer patronizing local medical stores to taking a sick child to a hospital or PHC, because the cost--both monetary and time--overrides the benefit of free medical treatment. The pie chart below shows the frequency of use of project health facilities by the 182 OVC treated.

Figure 2. Distribution of OVC Who Have Received Medical Attention at Project Health Institutions by the Number of Visits (n=182)



Source: Isiugo-Abanihe, 2002

The free medical services were extremely helpful in cases where hospitalization was required. Admission statistics show that appendectomy, malaria, typhoid fever, and bronchial pneumonia were the major reasons for admission in project health institutions in 2002. Most of the caregivers clearly cannot afford hospital admission costs; the peace of mind of knowing that there was free treatment was most valuable.

5. Programming Issues and Challenges

This was CEDPA's first venture in providing support for OVC, and the project has experienced various challenges and programming issues. Some aspects of the project have worked well (e.g., the education and health service package for indigent orphans); others are still struggling to take off (e.g., IGAs); and a few have been discontinued (e.g., micro-credit loans). Given the short implementation period, it might be too early to dismiss even the discontinued activities as failures. In any event, we have much to learn from our experience. This documentation process is the first step in offering a closer look at what needs to be done. Some issues and challenges follow.

1. Community Ownership: Despite the great involvement shown by the VCP area community members and stakeholders, the project is still viewed as a "CEDPA" project, being implemented in their community. The VCP project operates to (1)

mobilize communities around the issue, thereby “setting the spark” that results in community initiatives, or (2) to support and increase the capacity of already existing community initiatives. The challenge here is to change or transform a service delivery model, externally initiated and funded, into a community-owned effort.

2. Sustainability: In working with local grassroots organizations and implementing partners, the assumption is that if they receive technical support they will be able to run the projects smoothly at the end of the implementation period. Start-up workshops that focused heavily on ways to run project activities in an efficient manner leave the NGO or CBO with hardly any skills in seeking and obtaining funding from external sources. Given the high levels of poverty in the Benue community, “sustainability” cannot imply complete financial self-sufficiency. Local NGOs and CBOs need to learn to access donor funds both externally and locally through fundraising and proposal writing. ‘Sustainability’ in this case implies ability to obtain funds for continuation of project activities (Sussman 2002).

The IGAs have potential to provide ongoing financial support for school fees and health care, if they become profitable businesses. They also have the potential of providing income for the caregivers who are paid for their work. This reflects a different definition of “sustainability,” where activities continue to support themselves after the initial start-up funds from the donor (Sussman 2002). The challenge here is to build the capacity of caregivers and provide sufficient mentoring and supervision to enable them to run the already established IGAs in project community areas effectively.

3. Targeting and Selection: The initial identification and enumeration process defined an orphan as a child 0 -15 years of age, with one or both parents deceased from AIDS. This process was taken a step further to choose the most indigent of these orphans. Although the community thought this was the best way of avoiding bias in the selection process, the criteria may increase the stigma experienced by these orphans. It is not clear if bias was truly avoided.

In a resource-poor setting such as Benue State, the distribution of uniforms and sandals to a small group of orphans makes them stand out as the “privileged few,” creating jealousy from those who are equally poor, but do not benefit from the project activities. The orphans currently enrolled in the VCP are often referred to as “CEDPA Orphans.” Moreover, the choice of one orphan in a family that has more than one orphan poses problems.⁵ Other children in vulnerable situations, such as those who are living with parents who are too sick care for them and abandoned children, also need similar services. Better efforts must be made to ensure that community identification exercises result in the identification of the most vulnerable children.

4. Project Coverage: Because of limited funds, projects are restricted to the areas that the paid staff can cover. The VCP covers seven communities in two LGAs, with 5

⁵ The baseline study revealed that the mean average number of orphans in a fostering family in the project area is 3.5.

community health workers from the local government. With the rising incidence of HIV/AIDS (as is reflected in increased AIDS deaths), the number of orphans will continue to grow, and hiring additional staff for improved coverage may be necessary.

5. Income Generation Activities: Because most of the IGA activities became fully operational in the last year or so, concrete results have yet to be seen. In some cases community members are optimistic about the future of the economic activity (cassava plantation and Gari mill); some have confronted serious issues (micro-credit loan scheme and piggery farm); and for others, like the rice mill, it is too early to tell. There are several administrative details, such as hiring practices, fees charged for non-caregivers who use the facilities, and maintenance issues that need to be resolved. The challenge is to improve the capacity of the implementing organizations (like CWO and Opiatoha) to successfully manage these businesses. Effective supervision and monitoring for constant appraisal of project activities is an absolute necessity. Management and disbursement of the funds collected from the group IGA activities have been problematic. Also, how can we ensure that the profit, once made, would directly benefit the fostered children? Does increased income in the household translate into improved well-being of OVC in households?
6. Vocational Skills Training: The Benue State project supports almost 80 caregivers and orphans in various vocational training skills. The extent to which they will benefit financially from these skills is not known. The costs of the skills training and of enabling participants to utilize skills need to be determined. For example, equipping participants in tailoring apprenticeship with sewing machines was considered, but has not yet materialized. Another issue to be analyzed is the impact of vocational training on caregivers and OVC.
7. Health and Education Benefits: The VCP supports education and health expenses for selected orphans. This short-term, relief-oriented model was adopted due to the urgency expressed by USAID. Without continuous funds, this model for providing school and health expenses is not sustainable. The challenge here is to develop a model that can be sustained by the community, given the inevitable persistence of the orphan problem⁶. Issues of proximity to health centers need to be addressed, because as mentioned earlier most caregivers did not use the centers because of transportation costs.
8. HIV Prevention and Stigma Reduction: The project suffered a setback when a nationally televised documentary portrayed the Ogobia community as the community with the highest HIV prevalence in Nigeria. This resulted in silence about AIDS, and the implementing partners were subjected to violence and in one case expulsion from the community. HIV prevention activities performed by VCP implementers are limited to infrequent events such as World AIDS Day, which happens only once a year. The challenge now is incorporating HIV/AIDS prevention activities into the current

⁶ It is predicted that the number of orphans in Nigeria will rise from the current 900,000 to 2.6 million by the year 2010 (UNICEF, et al. 2000).

programming so that they will benefit the orphans, caregivers, other youth and community members.

9. Care and Support for People Living with HIV/AIDS: In the households where relatives are living with HIV/AIDS, care and support services are essential. Pathfinder International, an NGO previously supported by DFID, had a care and support project (which has since ended). Currently, no services have been documented in Benue. This necessitates follow up with participants in the Home Based Manual field testing in October 2002, to determine the extent to which they have implemented the proposed plan of action.
 - Psychological Support: The VCP has no evidence of PIC members following up or providing emotional and psychological support to the orphans and caregivers.
 - Nutritional Support: Although Benue prides itself as being the “Food Basket” of Nigeria, there is evidence of poor nutritional status of the children and caregivers. What is not known is the extent of the problem, and what role ignorance plays. Training of caregivers on cost-effective sustainable interventions to enhance household nutrition should be encouraged.
10. Project Implementing Staff – Capacity Development: Staff turnover has been high, both at CEDPA headquarters and at the field level. Even though the staff hired in Benue State were from the project communities and established a good rapport, they may not have had the necessary skills to provide ongoing technical assistance to the implementing partners. Social mobilization and start-up workshop training were offered to project implementers but very little follow-up and retraining were provided by CEDPA. How do we ensure prompt follow up to identify needs and weaknesses, and provide timely and appropriate responses?
11. Sexual Vulnerability of Female Children: In numerous discussions it became apparent there is a need to address the sexual vulnerability experienced by the female children. For example, two of the children became pregnant, and one of them terminated the pregnancy. CEDPA should make a special effort to develop sexuality and life skills training and make this training available to this project.

6. Lessons Learned

1. Education and health subsidies, or similar government-supported programs, are key to ensuring a child receives an education and remains relatively healthy. However, there are other competing factors such as contributing to the family labor force (working on the family farm) that might take precedence over education.
2. Providing special privileges to a group of orphans within a community can further contribute to stigma and discrimination.

3. The targeting and selection process, although decided upon by the community, left some families in situations where the families' biological children were excluded from receiving health and education services despite having similar needs to those of the orphans.
4. It is very important to have clearly identified objectives that all the stakeholders agree upon.
5. Community involvement does not necessarily translate into community ownership. Despite the heavy involvement of the community through donations, participation in IGAs, and even care of orphans, there was still a sense that the activities comprised a "CEDPA project." Very few community-initiated projects on the ground are in existence today. Involvement of the community in the design of the project (i.e., goals and objectives) is crucial. Community involvement at every step of the implementation process has the potential to reduce the stigma associated with HIV/AIDS.
6. Donors and implementing organizations should be very careful about how and where they choose to disseminate information collected from the community. They may be well intended, such as in cases where the intention is to create awareness of the problem or attract additional funding, but such publicity may impact the community negatively through further discrimination and stigmatization from the surrounding groups, as happened in the Ogobia case. The community members should agree upon where and how information is to be used. Socio-emotional support and counseling should be readily available to deal with any unintended outcomes.
7. Capacity building, refresher training, and follow-up are needed in these resource-poor areas. The project staff need training in financial management and monitoring and evaluation. PIC members require additional improvements in knowledge of HIV/AIDS transmission and prevention.
8. Social mobilization, including advocacy to state government officials, works in mobilizing community resources for orphans and caregivers. It also helps in reducing stigma.
9. Isolated HIV/AIDS awareness creation days such as World AIDS Day, do contribute somewhat to HIV prevention efforts, but a sound plan of action is needed to link consistent prevention activities to HIV services such as treatment/care, counseling and testing.
10. Adolescent reproductive health services are urgently needed in the community. Five of the adolescents enrolled in the program dropped out of school because of pregnancy.
11. With the establishment of IGAs within the project, an IGA specialist should be available to provide mentoring and monitoring of activities.
12. Proper community entry and involvement of the stakeholders is very important.

7. Next Steps

Plans are underway to modify the project, refine the project goal and objectives, and redesign the activities to ensure longer-term sustainability. The first step is to modify the project objectives.

The future **objectives** should be to:

- Advocate for state, and local government policy change that benefits all families and children affected by HIV/AIDS to ensure provision of health services and basic education at least through primary school and protection from both emotional and physical abuse for children identified by communities as “most vulnerable.”
- Strengthen the capacity of community-based organizations to provide support and care for OVC and their families through training.
- Increase the income of caregivers through proper management of the IGAs, and engage a consultant to place the activities under the rules that govern cooperatives in Nigeria to facilitate equal or fair distribution of funds earned under a common agreement adopted by the caregivers.
- Elicit communities’ commitment to and action for (1) meeting OVCs’ needs and (2) combating negative perceptions of the OVC in tangible ways, to be determined through VCP needs assessment and social mobilization exercises.
- Mobilize and strengthen community-based HIV/AIDS impact mitigation and prevention efforts, including reproductive health education and life skills targeted especially at adolescents.

Adaptations to improve the VCP **activities** include:

1. In the short term obtain waivers from Local Government Action Committee on AIDS/State Action Committee on AIDS for health services and fees for OVC. In the long term, advocate for policy change to provide free education for vulnerable children.
2. Develop a management information system (MIS) for proper monitoring and supervision.
3. Increase community mobilization efforts through wide-scale implementation of the CEDPA social/community mobilization model as a “jumping off point” for obtaining long-term, committed community support and input for both continuous identification of most pressing needs and feasible solutions for problems faced by OVC and their caregivers.
4. Step up capacity building of stakeholders, CBO members, community, caregivers, church groups to increase their ability to respond to the multi-sectoral nature of HIV impact e.g., care and support, prevention activities, advocacy, nutrition and food security, and emotional and psychosocial support.

Targets will be identified for each objective before the project resumes. Some key questions:

- What are the expectations for increased income, if any?
- What are the targets for education? Is it that all vulnerable children will have received a sixth grade education? Will this exclude some of the older children and therefore lessen the burden on local government?
- What will be the indicators of community commitment? Should an MOU be drafted in addition to the community's commitment to doing three tangible things for vulnerable children?

Monitoring and evaluation: The management information system will be developed in collaboration with community partners to ensure that information required for measuring project progress is collected and that all indicators important to stakeholders and feasible for collection are incorporated. The existing MIS will be modified to incorporate information that will allow us to:

- a. Monitor progress toward achieving goals by collecting data on:
 - Inputs (e.g., training sessions)
 - Outputs (e.g., people trained)
 - Outcomes (e.g., improved knowledge/skills, skills used from training sessions with caregivers, teachers, community partners (churches, health facilities, CBOs, etc. who are identified through situational analysis)
 - Information about children (this is sensitive and care should be taken), including name, address, resources provided (health, school, support groups – whatever interventions are determined by communities), guardian(s)' name/s, school attendance, and health card information.
 - Information on IGAs and cooperatives (money generated, money used, participation information (such as number of caregivers involved, etc.)
- b. Make decisions about the program and make changes in implementation as appropriate.
- c. Identify the missing link/s in the social mobilization process, which has worked beautifully in mobilizing resources that would foster community ownership. Possibly conduct a baseline assessment and document review on community cohesion, and develop a community efficacy index.

8. Conclusions

While the vulnerable children project had a strong component of direct assistance, the level of community participation and involvement was quite impressive. This attests to CEDPA's strong commitment to working with community-based groups as implementing

partners through building their capacity, along with community mobilization activities. The care and support activities of orphans and their caregivers and limited awareness and prevention activities, which translated into more opportunities for orphans and their caregivers, helped in opening up the minds of community members, increasing their acceptance, and reducing the stigma towards them. Full community commitment and involvement in supporting the existing family social networks still remain the most viable way forward. Continuous efforts need to be made to build and strengthen further the existing community efforts through capacity building in various areas—advocacy, care, support and prevention, emotional and psychosocial support, and income generation for longer-term sustainability. Also a multi-sectoral approach needs to be adopted to respond to the various needs of OVC and their families, mainly through referral and collaboration with both public and private sectors. Involvement of the children in the planning and design of programs should be considered in the future.

References

1. Adekunle, Adeyemi and Isiugo-Abanihe, Uche. *Vulnerable Children Project Baseline Study, Benue State Nigeria*. (Lagos: CEDPA, 2002).
2. Amolo, R. CEDPA Trip Report, 2002.
3. Bicego, G., Rutstein, S., Johnson, K. *Dimensions of the Emerging Orphan Crisis in sub-Saharan Africa*. (Elsilver Science Ltd, 2002).
4. CEDPA. *Quarterly Service Statistics Reports 2000-2001*. (Washington, DC: CEDPA, 2001).
5. Deinger, K., Garcia, M., and Sabarao, K. *AIDS-Induced Orphanhood as a Systematic Shock: Magnitude, Impact and Program Interventions*. (Washington, DC: World Bank, 2001).
6. Isiugo-Abanihe, Uche. *Vulnerable Children Project Evaluation Report*. (Lagos: CEDPA, 2002).
7. Kelly, R. CEDPA Trip Report, 2001.
8. Ministry of Health. *2001 HIV/AIDS Sentinel Report*. (Lagos: Ministry of Health, 2001).
9. Olajumoke, Uju. *Assessment of the Vulnerable Children Project, Otukpo, Benue State*. (Lagos: CEDPA, 2002).
10. Onumonu, Chinwe. *Care of Orphans and Vulnerable Children: The Experience of CEDPA in Nigeria*. (Lagos: CEDPA, 2002).
11. POLICY Project, The Futures Group. *HIV/AIDS in Nigeria: Overview of the Epidemic*. (Washington, DC: The Futures Group, 2002).
12. Subarao, K., and Coury, Diane. *Orphans in Sub-Saharan Africa Countries*. (Washington, DC: World Bank, March 2003).
13. Sussman, Linda. *Orphans and Vulnerable Children Programming Overview Report*. (Lagos: USAID, 2002).
14. UNICEF, UNAIDS, and USAID. *Children on the Brink 2002*. (Geneva: UNAIDS, 2002).